Government's Changing Role in Public Health

Presentation by Alan Levine

Secretary,

Louisiana Department of Health and Hospitals

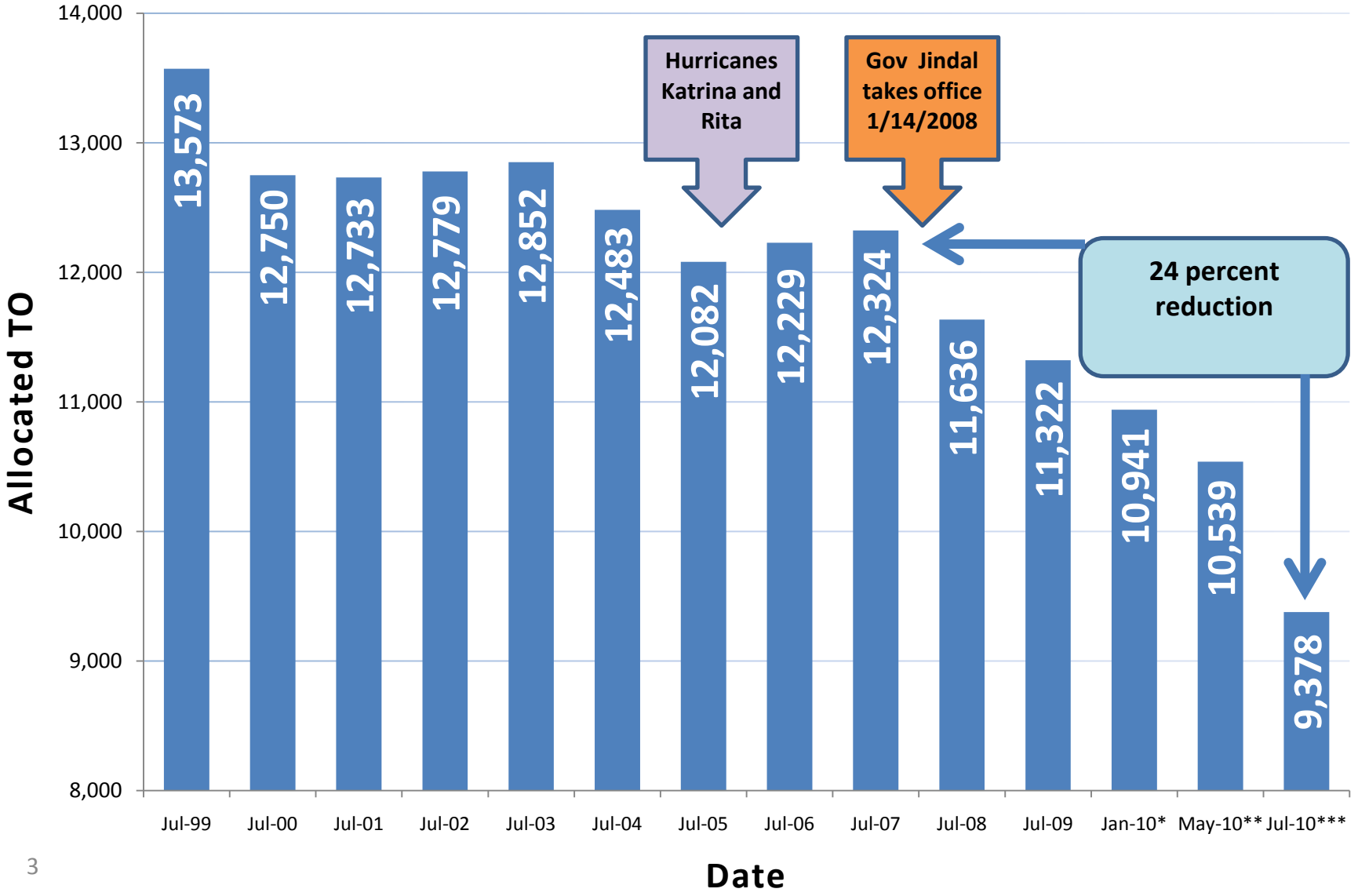
February 20, 2010

The challenges for Governors have never been greater – nor the expectations higher.

- Increasing demand for public services
- Aging of population and long-term care needs for disabled
- Increasing need for improved performance of K-12 and higher education
- Need to create diverse economies that grow jobs and create stable tax base

Can these things be done while meeting the public's expectation that government grow smaller?

Reduction in the Size of Government is Possible



While our health agency was getting smaller…

- Catapulted from 44th in child immunizations to 2nd in the nation while using pay for performance strategy recognized by CMS as a promising quality practice
- Moved up to our highest overall health ranking in 19 years
- Increased number of children insured by 10%, leading to a less than 5% rate of uninsurance
- Rolled out electronic prescribing in Medicaid
- Recognized by CMS as National Best Practice in Administrative efficiency and for 99% retention rate of children in coverage.
- Passed most sweeping Mental Health reforms in state history; expanded community-based care model; implemented evidence-based community mental health programs
- Initiated modernization of public hospital system – including privatization of Charity hospital in New Orleans and proposed closure of public hospital in Baton Rouge/creation of major academic medical center with Level 1 trauma care
- Privatized and downsizing state-operated institutions for persons with developmental disabilities – saving millions of dollars and providing increased community-based options
- Implementation and expansion of Rural Health Information Technology program bringing digital diagnostics rural communities with little access
- Passed Seafood Safety Act requiring labeling of imported seafood
- Significant investment in Health Information Technology- one of four winners of CMS Medicare Electronic Health Records Demonstration Project
- Launched **www.HealthFinderLA.gov,** giving consumers access to performance measures for hospitals, nursing homes and health plans
- Initiated most sweeping reform of Medicaid in the state's history
- Passed new long-term care waiver to improve services for seniors
- Responded to a flood, two major hurricanes , an oil spill and a global flu pandemic.

Two major hurricanes tested Louisiana's disaster readiness, including the largest medical evacuation in nation's history

The authority and accountability lies within the public sector, but the resources are primarily in the private sector. Louisiana has worked hard to create a meaningful public-private health and medical response network.

In addition to the state's regional leadership, our Unified Command is composed of public and private entities:

- Hospital Designated Regional Coordinators
- EMS Designated Regional Coordinators
- Home Health Designated Regional Coordinators
- Mass Fatality Designated Regional Coordinators

Distribution/transport activities relied heavily on private partners:

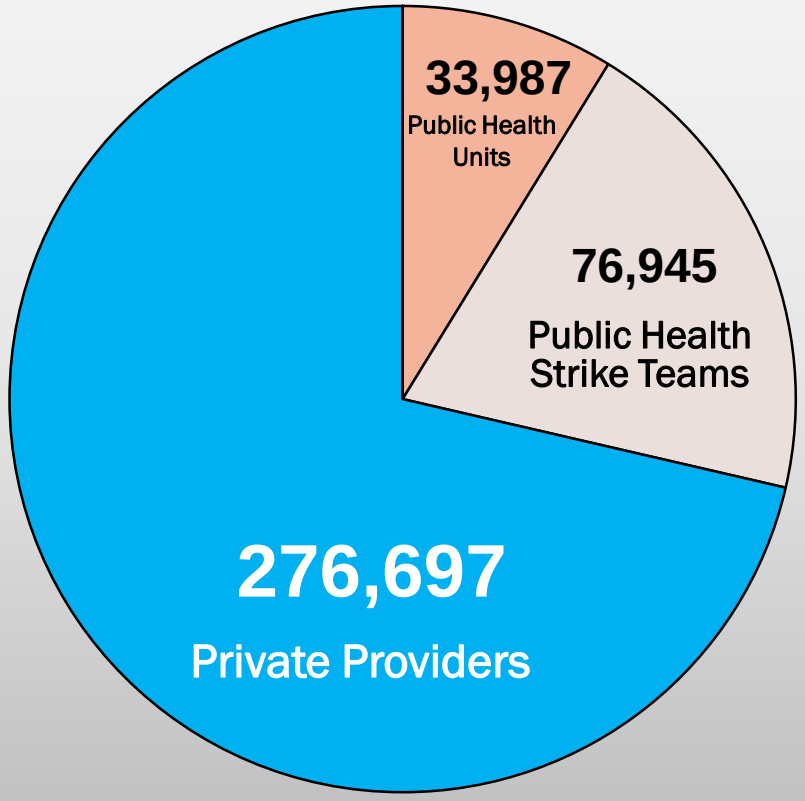
- Hospitals
- Entergy
- Airgas
- Emergency Medical Services

Gustav /Ike Fast Facts:

- 1632 volunteers deployed, providing services valued at over $31,000/hr.
- 75,000 people sheltered
- 78 hospital evacuations
- 42 hospital power outages
- Operated 8 medical special needs shelters and 4 critical transportation needs shelters
- Evacuated 11,000 people from hospitals and nursing homes
- Evacuated 2 million residents from the entire coast of Louisiana

The private sector played a crucial role during Louisiana's H1N1 pandemic response, which earned praise from CDC

71.4% of H1N1 Vaccinations were administered by private providers



Partnerships with:

- **Pharmacies:** Issued emergency order and protocol that allowed for the administration of influenza vaccination by eligible pharmacists across the state. We pre-positioned antiviral medication at a network of community pharmacies
- **Nurses:** Worked with Louisiana State Nursing Association and the Louisiana School Nursing Association enabling us to license nearly 1,000 nurses to become nurse vaccinators.
- **FQHCs, RHCs and Home Health Clinics**: Encouraged FQHCs, RHCs and home health agencies to register to receive H1N1 vaccine at no cost through the state immunization program.
- **Faith-Based Organizations**: Worked with organizations such as the Louisiana Interfaith Disaster Recovery Network to provide educational awareness to targeted populations.

These partnerships helped Louisiana earn praise from CDC for our preparedness efforts, including use of real-time data and ability to anticipate shortfalls and facilitate requests for additional product.

Public health challenge – We ignore the fact Medicaid is the most relevant vehicle for improvement of health for the poor, yet we relegate it to simply pay claims for sick care.

- Why do we isolate Medicaid as a safety net payer of claims rather than leverage its capability to improve basic public health?
- Why do we isolate public health functions as if they are separate from the population Medicaid serves, and then create and invest in an entirely redundant infrastructure that becomes institutionalized?
- Consider that Medicaid grew by 7.9% this year – more than expected, and its expected to continue growing at a higher rate – particularly if Congress expands it.
- Performance in Medicaid is poor, and states spend more time and effort fighting over rates than they do articulating ways to align incentives to improve public health outcomes

So, if the "public" health plan for the poor is failing, then what should the government's role be?

- Organize Market Driven Systems/Networks of Care
- Set Performance Standards and priorities for improvement
- Measure and make results transparent
- Rewards and consequences for organized systems based on performance

- Move Government away from rate setting and creation of different funding streams to role where policy is articulated and carried out by the organized networks.
- Should not replicate what the private market is doing, but rather, leverage it.
- Government does not have to be a provider, an insurer, the payer, and the payee all at the same time.

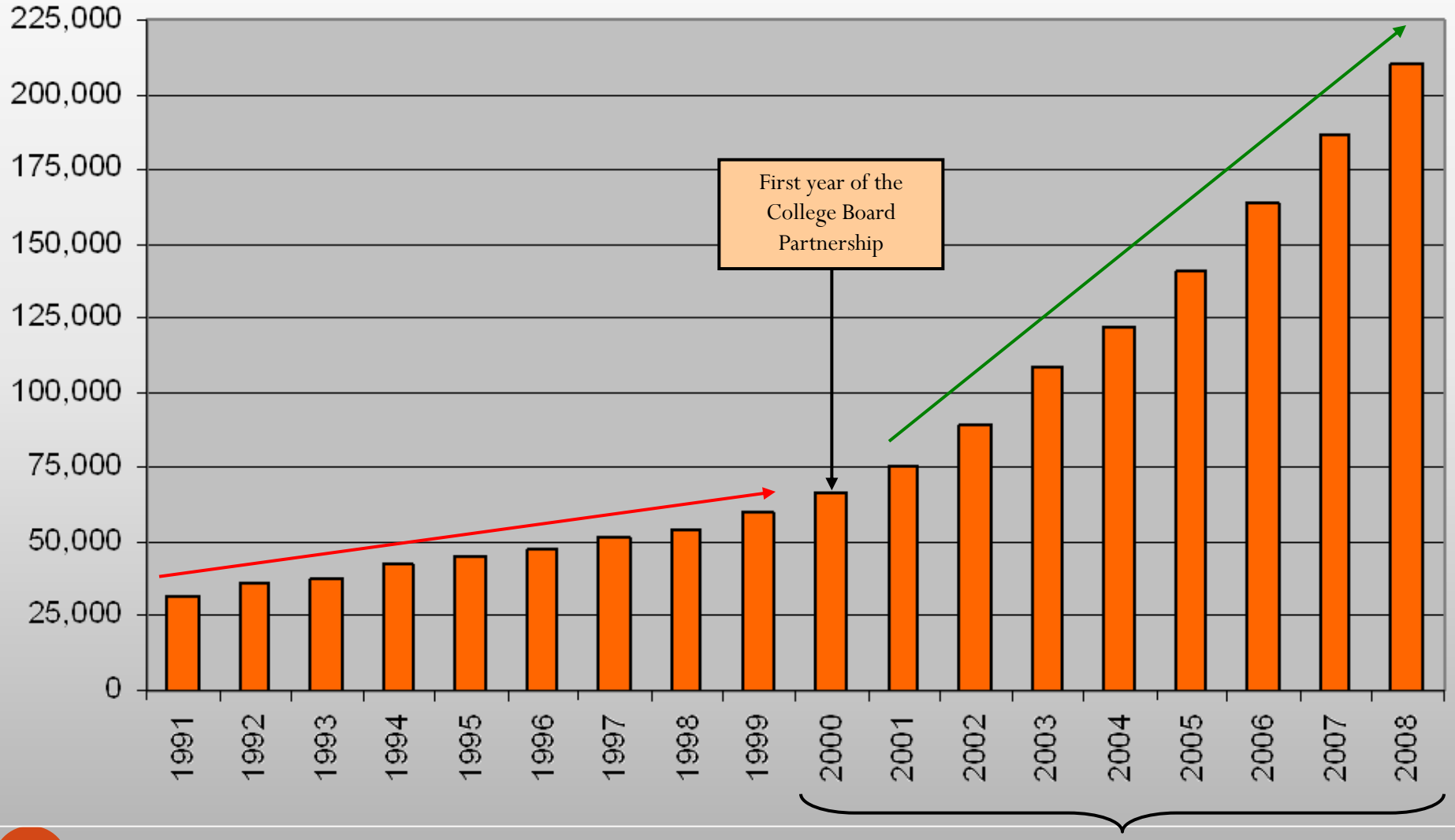
Question:

- Can you recall the last time the debate in your legislature was about quality, system performance and outcomes rather than provider rates?

- Wouldn't it be classic to determine which organized systems of care were improving well-child checkups, breast cancer screenings, reducing smoking, reducing the rate of teen suicides, improving immunizations, and reducing avoidable hospitalizations….and then rewarding them? Or holding accountable those organized systems which perform poorly?

AP Exams Taken

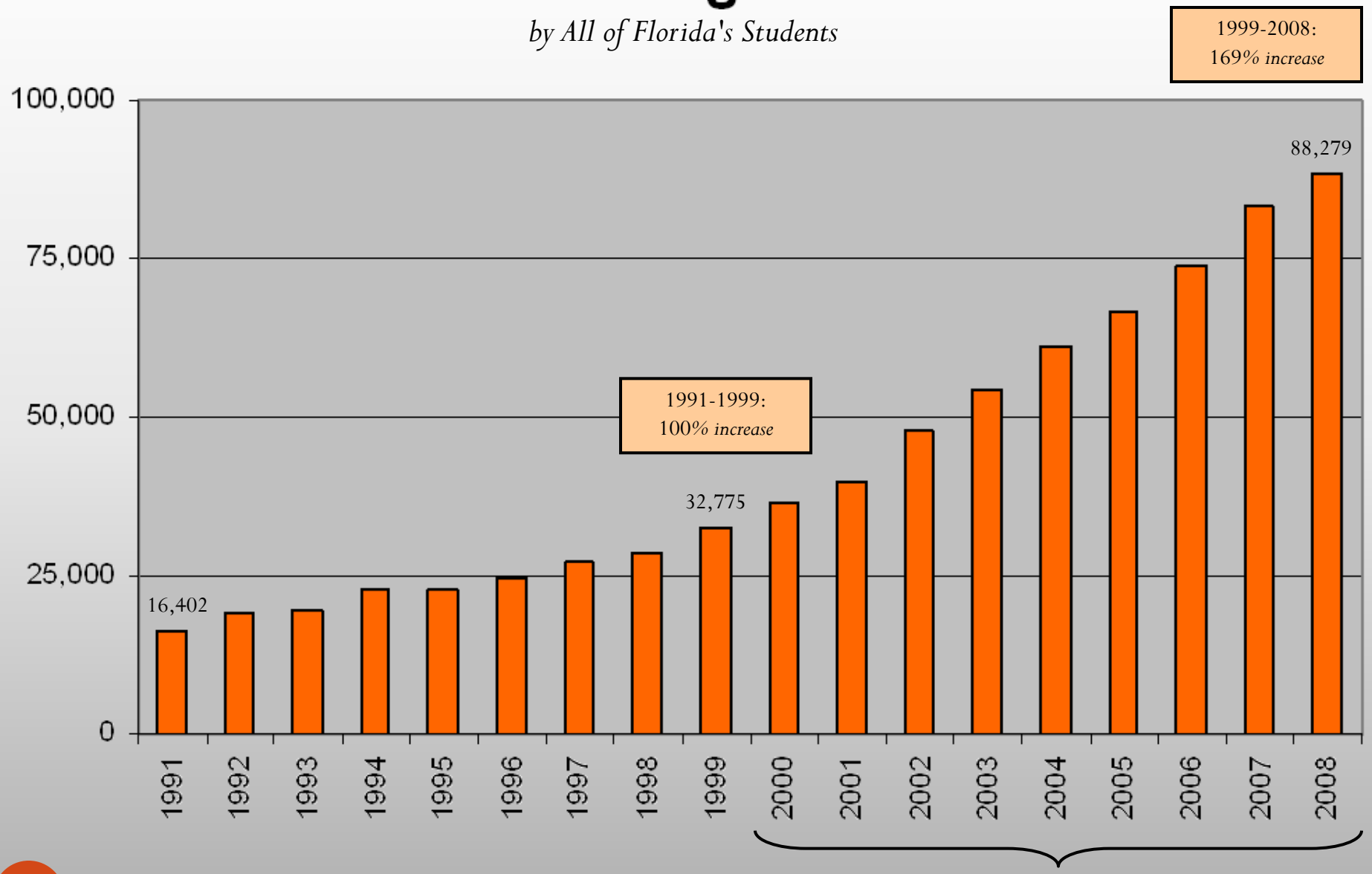
by All of Florida's Students



Florida Partnership for Minority & Underrepresented Students *(including the AP Teacher Bonus Program)*

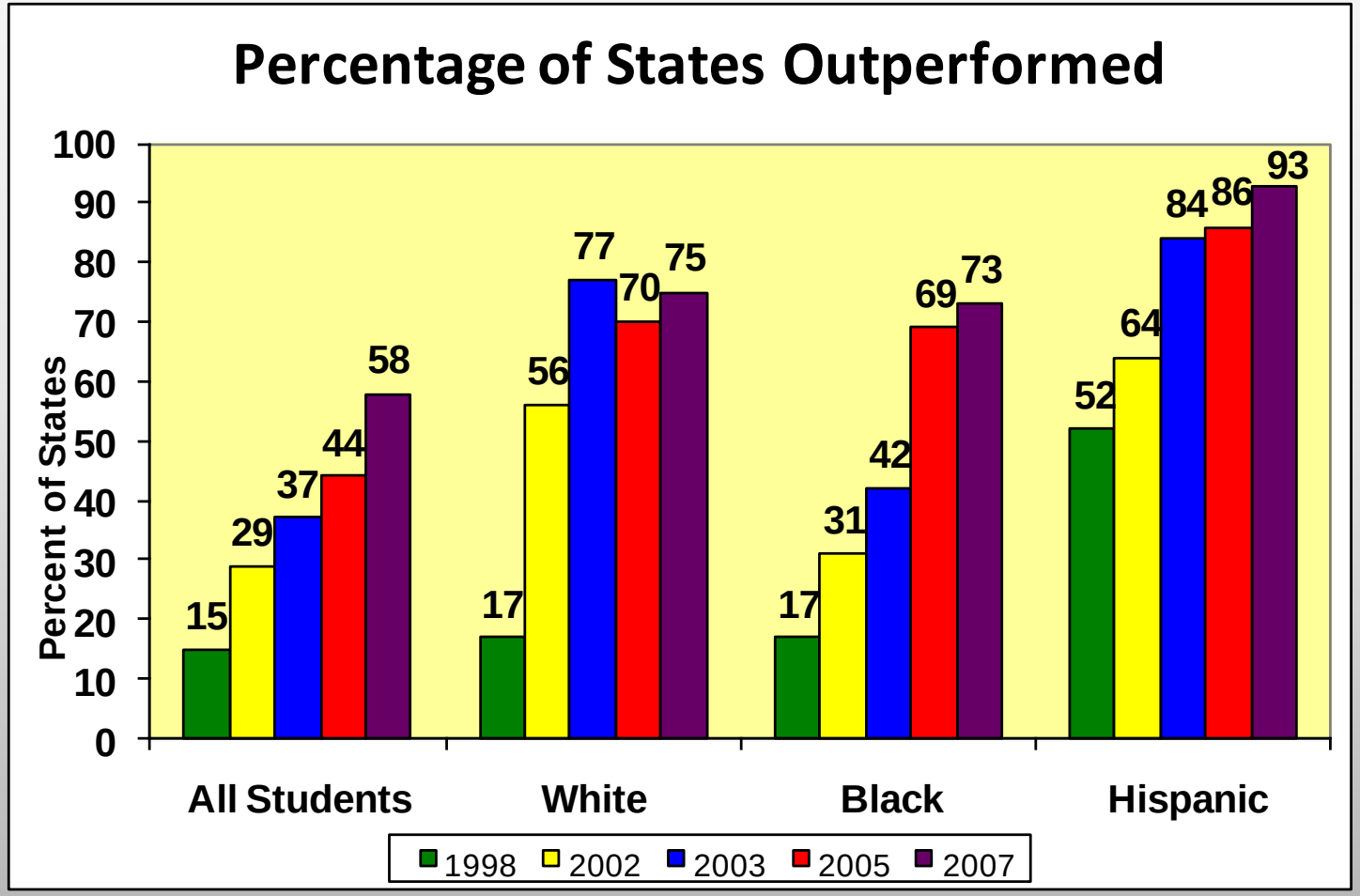
AP Passing Scores

by All of Florida's Students



Florida Partnership for Minority & Underrepresented Students *(including the AP Teacher Bonus Program)*

NAEP: 4th Grade Reading
1998-2007



12

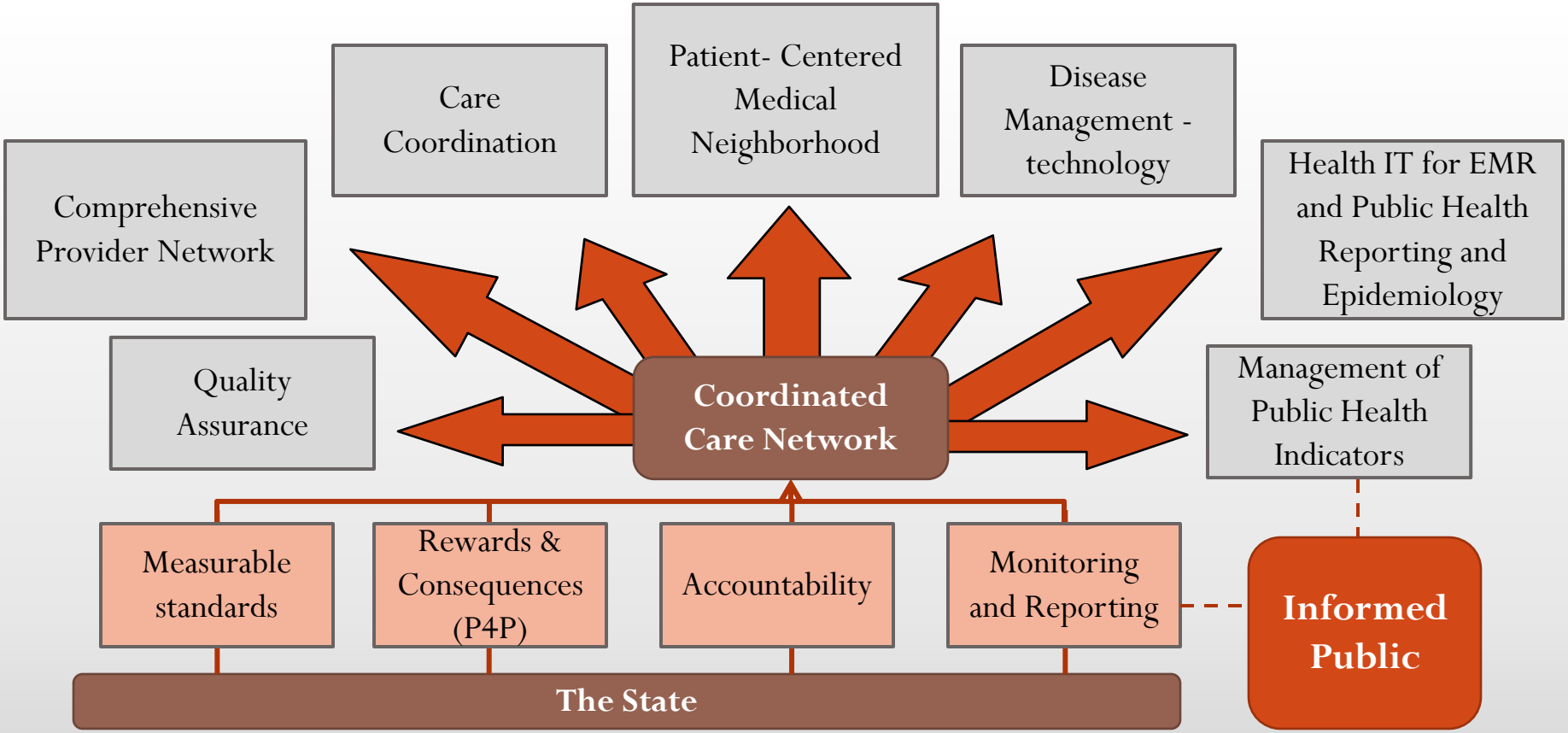
Cornerstones of Florida's 1999 Education Reforms

- High Standards & Expectations
  - Testing all students and holding them to same standards
- Measurement & Reporting
  - Grading schools A, B, C, D, F
- Rewards and Consequences for Results
  - Providing cash awards to schools that improve a letter grade
  - Allowing students in F schools to attend a higher performing public or private school
- Choice and Competition
  - Providing vouchers for kids with disabilities, low-income students, students in failing schools, and increasing charter school and virtual school options

Health Care is behaving exactly as designed – reward poor outcomes - punish improvement

- "Pay and Chase" system -
- Dartmouth study - $700 billion spent annually that does nothing to improve care or outcomes.
- In a fragmented fee-for-service system, everyone gets paid. And, since there is no connection or shared risk between the system and the costs, where are the aligned incentives to reduce this system failure? - Ex: Birth Outcomes
- Creating a system of care where incentives are aligned to improve outcomes will lead to market innovation and an energetic shift in focus.

Profit should not be derived from the failure of public health, but rather the improvement of it.



Coordinate Care Networks:

- Increase care coordination through the medical neighborhood system of care
- Provide predictability of expenditures
- Increase provider and payer accountability for outcomes
- Increase access to care by requiring adequate networks of physicians
- Substantially reduce fraud and abuse
- Increase patient and provider choice
- Leverage state dollars with those invested by private payers and Medicare

Medicaid Reform in Florida has yielded higher satisfaction, improved quality, and lower costs.

- While Per-Member Per-Month costs grew by $150 for SSI enrollees in control counties after reform, those PMPM costs actually *decreased* by $25 in the reform counties.
- The results were even more striking for enrollees of Provider Service Networks, where SSI enrollee PMPM decreased $95 in reform counties while increasing by $178 in control counties.
- On a scale of 1-10 (10 being the best)
  - Nearly 90% reported overall satisfaction with care at 7 or above.
  - 83% reported overall satisfaction with their plan at 7 or above.
- As many as 81% of enrollees were actively engaged in choosing their plan
- HEDIS Measure Improvement – 2009 Reform
  - Diabetes – LDL Screening: 80.2%
    - 6.4 percentage points higher than non-reform; 9.2 percentage points higher than national mean
  - Well-Child 3-6 Years: 75.7%
    - 3.2 percentage points higher than non reform; 8.9 percentage points higher than national mean
  - Adult Access to Preventive Care 65+: 83.6%
    - 8.9 percentage points higher than non-reform; 4.8 percentage points higher than national mean
  - Diabetes HbA1c Testing: 80.1%
    - 5 percentage points higher than non-reform; 2.1 percentage points higher than national mean

The same has been seen in other states…

Cost and Satisfaction

- Kentucky Passport:
  - Medical cost trends have averaged 5% annually for the network compare to a regional average of 10% in 2007
- Arizona:
  - An 11% savings in medical service costs in first 10 years of their waiver. Earlier, more frequent and more complete care for children. "Better access to good quality care at lower cost."
- Missouri
  - Managed Medicaid enrollees reported high satisfaction (above 7 on CAHPS)
    - Satisfaction with Plan – 76%
    - Satisfaction with Care – 78%
    - Getting care quickly – 90%

Quality

- Kentucky Passport:
  - Rated excellent by NCQA in all health plan categories
  - EPSDT screenings at 93%
- New York:
  - Medicaid health plans improve access to critical preventive care over Fee for Service
    - Cervical cancer screenings of 71% vs. 39% in FFS
    - Diabetes testing of 76% vs. 32% in FFS
- Tennessee:
  - TENNCare saw an increase in MCO HEDIS rates from 2008 to 2009 for:
    - Childhood Immunization Status
    - Breast Cancer Screenings
    - Appropriate Treatment of Children with Upper Respiratory Infection and with Pharyngitis
    - Well-Child Visits in the First 15 Months of Life,
    - Children and Adolescents' Access to Primary Care Practitioners (ages 12-24 months and 25 months-6 years).